Health History

Patient Name: ____ Date: _________ Male Female

Date of Birth: __________________ Age: ______ Date of last physical exam: __________________

Who is your Primary Care Provider: ____________ Who referred you to our office? ____________

Current weight __________ Height: __________ Date of last Flu shot: ____________________

Reason for your visit: ____

Allergies to any medication or substances: ____

____ Are you allergic to Latex products? __________

Current medications with dosages, and how often you take the medication. Please include any over the counter vitamins, herbal or dietary supplements: ____

____

____

Significant current or past medical conditions or injuries: ______________________________

____

____

Previous surgeries and dates of procedures: ____

____

Previous hospitalization –date and reason for hospital stay: ____________________________

____

Have you ever had a blood transfusion? Yes No Date: ______________________________

Do you have a history of any of the following?

Blood clots: Yes No Date: _______ Location of clot: ______________________________

Treatment: ____

Bleeding abnormalities: Yes No Explain: ____

High blood pressure: Yes No Depression: Yes No

Chronic lung condition Yes No Use of oxygen or CPAP Yes No Settings ______________

Heart condition Yes No Type of condition ______________________________________

Anesthesia Complications Yes No Explain: ______________________________________

Do you use any of the following: Type of product, how much and how often?

Street Drugs Yes No ____

Tobacco products Yes No ____

Have you ever used tobacco products? _______ When did you quit? ______________________

Are you currently pregnant? If yes, estimated date of delivery_____________________________

Any other conditions or significant information needed to assist in you care not otherwise listed:

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To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform Dr. O'Holleran of any changes to my health.

____ ____________________

Signature of patient or guardian Date

____

FOR STAFF USE ONLY

BP ___________ Pulse ____________